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Access to Health Care Services in Rural Areas: Delivery and Financing Issues

The articles in this issue of the Health Care Financing Review *focus on delivery and financing of health care to rural areas. Following are the abstracts for articles included in this issue. The* Review *may be ordered from the U.S. Government Printing Office, Superintendent of Documents, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. A one-year subscription is $30.00; single issues are $19.00. Click here to see a subscription form. For information on submitting articles to the* Review*, contact Linda Wolf, Editor-in-Chief, at (410) 786-6572 or by e-mail LWOLF@HCFA.GOV. Statements contained in* **Review** *articles are solely those of the authors and do not express any endorsement by the Health Care Financing Administration .*

Issues in Rural Health: Access, Hospitals, and Reform

Sheldon Weisgrau, M.H.S.

This overview discusses articles published in this issue of the *Health Care Financing Review*, entitled "Access to Health Care Services in Rural Areas: Delivery and Financing Issues." These articles focus on the following topics: rural hospitals (including closures, the impact of Federal grants, network development, and costs), managed care in rural areas, telemedicine, and the delivery of mental health services to rural Medicaid beneficiaries.

Access to Care in Rural America: Impact of Hospital Closures

Margo L. Rosenbach, Ph.D., and Debra A. Dayhoff, Ph.D.

This article employs a quasi-experimental, pre/post comparison group design to determine whether rural hospital closures (n=11) have had a detrimental impact on access to inpatient and outpatient care for the Medicare population. Closure areas experienced a significant decrease in medical admissions, although admission rates remained higher than in comparison areas. Physician services were not found to substitute for inpatient services following a closure. No adverse impacts on mortality were observed. Patients in closure areas were more likely to be admitted to urban teaching hospitals following the closure of their local hospital.

Do Transition Grants Help Rural Hospitals?

Judith Wooldridge, M.A., Valerie Cheh, Ph.D., Rachel Thompson, M.P.H., Lorenzo Moreno, Ph.D., and Nancy Holden, M.A.

Congress introduced the Rural Health Care Transition (RHCT) Grant Program in 1989 to assist financially troubled, small rural hospitals. This article discusses grant effects on the second cohort of hospitals to complete their 3-year grants. Although three-quarters of the grantees implemented all or most of their goals, 11 percent could not implement a viable project. Grantees added or upgraded 523 services with the help of their grants, especially outpatient and social services, most of them financially self-supporting. Except among the largest hospitals, there was no evidence that the grants improved grantee finances. Management appeared unaffected by the grants.

Rural Hospital Networks: Implications for Rural Health Reform

Ira Moscovice, Ph.D., Jon Christianson, Ph.D., Judy Johnson, M.H.S.A., John Kralewski, Ph.D., and Willard Manning, Ph.D.

This article summarizes the perspectives gained in the course of evaluating a 4-year demonstration program that supported rural hospital networks as mechanisms for improving rural health care delivery. Findings include: (1) joining a network is a popular, low-cost strategic response for rural hospitals in an uncertain environment; (2) rural hospital network survival is enhanced by the mutual resource dependence of members and the presence of a formalized management structure; (3) rural hospitals join networks primarily to improve cost efficiency but, on average, hospitals do not appear to realize short-term economic benefit from network membership; and (4) some of the benefits of these networks may be realized outside of the communities in which rural hospitals are located.

Variations in Rural Hospital Costs: Effects of Market Concentration and Location

W. Bruce Vogel, Ph.D., and Michael K. Miller, Ph.D.

This article explores two neglected questions: (1) Does the relationship between hospital concentration and costs vary between urban and rural markets? and (2) Do hospital costs in non-metropolitan areas vary with rurality? Covariance models using 1992 data reveal that: (1) Although metropolitan and urban markets exhibit a negative relationship between hospital average costs and market concentration, non-metropolitan and rural markets fail to exhibit any relationship between costs and concentration; and (2) among non-metropolitan hospitals, only hospitals located in single-hospital communities have lower costs than their counterparts in multiple-hospital communities, once other factors are held constant.

Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?

Carl Serrato, Ph.D., Randall S. Brown, Ph.D., and Jeanette Bergeron, M.A.

Only 17 of the 38 health maintenance organizations (HMOs) that have Medicare risk contracts and offer coverage to commercial clients in rural counties include the rural counties in their Medicare plan service areas. Rural counties in which HMOs offer Medicare coverage have higher adjusted average per capita costs (AAPCCs), larger populations, and more physicians per capita than rural counties excluded by risk plans. Interviewed plans cite low and erratic AAPCCs, scarcity of potential enrollees, lack of negotiating power with physicians, and adverse selection as drawbacks in rural areas. Proposed changes to the payment methodology would probably lead HMOs to increase their Medicare offerings in urban fringe areas, but not in isolated rural areas.

Patterns of Health Maintenance Organization Service Areas in Rural Counties

Thomas C. Ricketts, Ph.D., M.P.H., Rebecca T. Slifkin, Ph.D., M.H.A., and Karen D. Johnson-Webb, M.A.

This study analyzes the 1993 *National Directory of HMOs* to determine the extent to which rural counties are included in health maintenance organization (HMO) service areas. Two specific questions are addressed: (1) How do the patterns of service areas differ across HMO model types? (2) What are the characteristics that distinguish rural counties served by

HMOs from those that are not? Although a majority of rural counties are in HMO service areas, substantially fewer are served by non-individual practice association (non-IPA) models. Access to HMO services is found to decrease with county population density, and adjacency to metropolitan areas is an important predictor of inclusion in service areas.

Effects and Effectiveness of Telemedicine

Jim Grigsby, Ph.D., Margaret M. Kaehny, Elliot J. Sandberg, M.D., Robert E. Schlenker, Ph.D., and Peter W. Shaughnessy, Ph.D.

The use of telemedicine has recently undergone rapid growth and proliferation. Although the feasibility of many applications has been tested for nearly 30 years, data concerning the costs, effects, and effectiveness of telemedicine are limited. Consequently, the development of a strategy for coverage, payment, and utilization policy has been hindered. Telemedicine continues to expand, and pressure for policy development increases in the context of Federal budget cuts and major changes in health service financing. This article reviews the literature on effects and medical effectiveness of telemedicine. It concludes with several recommendations for research, followed by a discussion of several specific questions, the answers to which might have a bearing on policy development.

Access of Rural AFDC Medicaid Beneficiaries to Mental Health Services

David Lambert, Ph.D., and Marc S. Agger, M.P.H.

This article examines geographic differences in the use of mental health services among Aid to Families with Dependent Children (AFDC)-eligible Medicaid beneficiaries in Maine. Findings indicate that rural AFDC beneficiaries have significantly lower utilization of mental health services than urban beneficiaries. Specialty mental health providers account for the majority of ambulatory visits for both rural and urban beneficiaries. However, rural beneficiaries rely more on primary-care providers than do urban beneficiaries. Differences in use are largely explained by variations in the supply of specialty mental health providers. This finding supports the long-held assumption that lower supply is a barrier to access to mental health services in rural areas.

Hospital Department Cost and Employment Increases: 1980-92

Jerry Cromwell, Ph.D., and Barbara Butrica

Hospital costs have continued to rise at rates well in excess of inflation generally, even after the introduction of Medicare's per case prospective payment system (PPS). This article uses a hospital subscriber microcost reporting system to show trends in costs, wages, labor hours, and outputs for more than 50 individual departments from 1980-92. Descriptive results show dramatic growth in the operating room, catheter lab, and other technologically driven cost centers. Administrative costs also increased rapidly through 1988, but slowed thereafter. The paperwork billing and collection burden of hospitals is estimated to be $6 billion in 1992, or approximately 4 percent of total expenses.

Medicaid Fees and the Medicare Fee Schedule: An Update

Stephen A. Norton

This study analyzes changes in Medicaid physician fees from 1990 to 1993. Data were col-

lected on maximum allowable Medicaid fees in 1993 and compared with similar 1990 Medicaid data as well as the fully phased-in Medicare Fee Schedule (MFS). The results suggest that, on average, Medicaid fees have grown roughly 14 percent, but considerable variation continues to exist in how well Medicaid programs pay across types of services, States, and census divisions. Medicaid fees remain considerably lower (27 percent for the average Medicaid enrollee) than fees under a fully phased-in MFS. Medicaid fees for primary-care services were, on average, 32 percent lower.

Variations and Trends in State Nursing Facility Capacity: 1978-93

Richard DuNah, Jr., M.A., Charlene Harrington, Ph.D., Barbara Bedney, M.S.W., and Helen Carillo, M.S.

The demand for nursing facility (NF) beds has been growing with the aging of the population and many other factors. As the need for nursing home care grows, the Nation's capacity to provide such care is the subject of increasing concern. This article examines licensed NFs and beds, presenting data on trends from 1978-93. Measures of the adequacy of NF beds in States are examined over time, including the ratio of beds per aged population, occupancy rates, and State official's opinions of the adequacy of supply. State and regional variations are shown over time, and we speculate on the factors which may be associated with the variation.

DataView: State Health Expenditure Accounts: Building Blocks for State Health Spending Analysis

Katharine R. Levit, Helen C. Lazenby, Cathy A. Cowan, Darleen K. Won, Jean M. Stiller, Lekha Sivarajan, and Madie W. Stewart

The dynamics of financing health care among various levels of government and the private sector are rapidly changing; structural relationships among health care providers are also being altered. These changes are placing increased importance on State-level expenditure estimates that will be instrumental in measuring the differential impact of Federal policies and State-specific initiatives on individual States. This article presents personal health care expenditures (PHCE) for 1980-93. Statistics show wide variation in level and rate of growth of regional spending per person. These statistics also quantify differences in both the percent of health care costs in each State borne by Medicare and Medicaid and in the proportion of each State's economy devoted to the provision of health care.

MCBS Highlights: Ownership and Average Premiums for Medicare Supplementary Insurance Policies

George S. Chulis, Ph.D., Franklin J. Eppig, Ph.D., and John A. Poisal

This article describes private supplementary health insurance holdings and average premiums paid by Medicare enrollees. Data were collected as part of the 1992 Medicare Current Beneficiary Survey (MCBS). Data show the number of persons with insurance and average premiums paid by type of insurance held—individually purchased policies, employer-sponsored policies, or both. Distributions are shown for a variety of demographic, socioeconomic, and health status variables. Primary findings include: Seventy-eight percent of Medicare beneficiaries have private supplementary insurance; 25 percent of those with private insurance hold more than one policy. The average premium paid for private insurance in 1992 was $914.